BRIGHT SMILES 4 KIDS

Of Bala

PATIENT INFORMATION

Patient's Name:_________________________ Nickname:_______________________

Street Address:____

City:________________ State:________ Zip:_________ DOB:_______ Gender: M / F

PARENT/GUARDIAN INFORMATION

Name:______________________________ DOB:___________________

SS#:_______________ Email:____

Phone:_______________________ (Home) Phone:___________________________ (Cell)

☐ Check box if address is the same as above

Street Address:____

City:_________________________ State:__________________ Zip:_______________

Employer:________________________________ Work #:_______________________

INSURANCE INFO

Name of Insured:___________________________________ DOB:_______________

Relationship to Patient:______________________ SS#:______________________

Insurance Company:___________________ Patient ID:_______________________

MEDICAL/DENTAL HISTORY:

Patient Name:________________________ DOB:____________ Age:_________

Primary Reason for Today's Visit?:____

Has your child recently seen a dentist? Y / N If yes, why?______________________

Previous Dentist:____

Last Exam Date:______________________ Date of Last Dental X-Rays:____________

Has the child had problems associated with dental treatment? YES / NO
Is the child taking fluoride supplements? YES / NO
Does the child brush / floss teeth daily? YES / NO

Habits (circle all that apply):

✔ Thumb/ finger sucking ✔ Pacifier ✔ Tongue Thrust

✔ Grind Teeth ✔ Mouth Breather ✔ Other:_____________________

Child's Physician Name:_______________________ Phone:______________________

Current medications:____

Has your child been diagnosed and/or treated for any of the following? (please circle all that apply)

✔ ADD/ ADHD ✔ Autism Spectrum ✔ Diabetes ✔ Heart Murmur

✔ Hepatitis ✔ Liver Problems ✔ Developmental Delay ✔ Asthma

✔ HIV / AIDS ✔ Cancer ✔ Epilepsy ✔ Congenital Heart Disease

✔ Sickle Cell Disease ✔ Surgery / Hospitalization ✔ Other:___________________________

Allergies:____

The information I have provided is correct to the best of my knowledge and I understand that it will be held to the strictest of confidence and it is my responsibility to inform *Bright Smiles for Kids* of any changes in my child's medical history.

________________________________ ___________________________

PARENT/GUARDIAN SIGNATURE **DATE**

DELEGATION OF POWER BY PARENT OF GUARDIAN

I, ______________________________ give my consent to allow person(s) named below other than me to accompany and oversee my child for dental appointments or to make payment for dental services also to provide consent for treatment or changes in treatment. I understand, I can revoke this consent at any time by providing written notice.

1.______________________________ 2.________________________________

3.______________________________ 4._________________________________

_________________________________ _____________________

PARENT/ GUARDIAN SIGNATURE **DATE:**

As the dental professionals of Bright Smiles, we consider it of utmost importance to help protect the health of our patients' teeth, gums, implants, and restorations as well as overall health. Detection of disease and diagnosis begin with a comprehensive dental exam, an up-to-date medical and dental history, up-to-date X-Ray's, and full-mouth periodontal probing that includes a new focus on inflammation identification. Our providers adhere to this Standard of Care and in order to do so they provide treatment based on patient needs NOT insurance coverage. "One size does NOT fit all" when it comes to establishing X-ray schedules, hygiene schedules, etc. The providers take into account the patient's oral health condition, age, risk for disease and any signs and symptoms of oral disease that the patient might be experiencing.

It is your responsibility as the insured, to understand your individual plan and any services and frequency limitations. As a courtesy we do check eligibility of the plan and upon request we can check treatment frequency limitations. Our mission at The Dental Spa is to deliver premium dental care to the Main Line and beyond, serving all ages with a focus on enhancing health and well-being. We are dedicated to providing exceptional, patient-focused services that significantly improve life quality through advanced care and technology.

I understand that it is my responsibility to know my insurance coverage, I also understand that I can, at any time, ask for and receive estimates on X-ray's and any treatment.

X____

Parent/ Legal Guardian

CREDIT CARD ON FILE AGREEMENT

The Dental Spa and Bright Smiles 4 Kids have implemented a new credit card policy. Like many other medical or dental offices, we have adopted a similar policy. We kindly request a credit card from our patients' guardian/guarantor, which may be used later to pay any balance that may be due on your bill. Co-pays are still due at the time of service. At registration and/or check-in, your credit card information will be obtained and kept securely until your insurance(s) have paid their portion and notifies us of the balance due, if any.

The information will be held securely until your insurance has paid their portion of the claim and notified us of any additional amount owed by the patient. At that time, we will notify you that your outstanding balance will be charged to your credit card. You may call our office if you have a question about your balance. We will send you a receipt for the charge. This "Card-on-File" program simplifies payment for you and eases the administrative burden on your provider's office. It reduces paperwork and ultimately helps lower the cost of healthcare. If you have any questions about the card-on-file payment method, please do not hesitate to let us know: 610-664-7244

By signing below, I authorize The Dental Spa and/or Bright Smiles 4 Kids to keep my signature and my credit card information securely on-file in my account. I authorize them to charge my credit card for any outstanding balances when due.

□Visa □MasterCard □Discover □American Express

Name on Card (Print): ____

Cardholder Relationship to Patient: ______________________________________

Credit Card Number: ____________________Exp. Date: ___/____

Please fill out information below for any person(s) you authorize this credit card for:

Patient Full Name (Print): ____________________________ DOB: ___/___/_____

Patient Full Name (Print): ____________________________ DOB: ___/___/_____

Credit Card Holder's Signature: ___________________________ Date: ______________

INSURANCE FILING POLICY

Bright Smiles for Kids will be more than happy to file and track any dental insurance claims on the patient's behalf as a courtesy; however, the guarantor of the patient account is responsible for the cost of the dental treatment.

The ultimate responsibility of knowing the patient's plan lies between the guarantor, the employer, and the contracted insurance carrier. Due to the vast number of insurance carriers, varied plans and changing agreements, ***Bright Smiles for Kids*** is not able to be expertly versed in all plans, at all times.

Please be aware that ***Bright Smiles for Kids*** cannot guarantee the insurance carrier's payment. It is up to the parent/legal guardian to know the patient's policy benefits and limitations. The total treatment cost provided from ***Bright Smiles for Kids*** is an estimate based on the information we have on file for the patient's specific insurance plan.

If the patient has dual coverage dental insurance, this does not always mean that dual payment is received. Some carriers have a non-duplication clause. If the guarantors company reimburses for a treatment, the secondary company may not. Please be aware of the guarantor's policies.
If the insurance carriers on file charge during treatment, the guarantor must notify our office immediately. This could change the original contract and adjustments may need to be made.

I have read and understand the above written insurance filing policy of ***Bright Smiles for Kids***. I understand that any monies not paid by my insurance carriers, for any reason, shall be the responsibility of the guarantor.

________________________________ ____________________

Parent/Guardian (printed) **DATE**

____

Parent/Guardian (signature)

FINANCIAL AGREEMENT

I ACKNOWLEDGE THAT PAYMENT IS DUE AT THE TIME OF TREATMENT, UNLESS OTHER ARRANGEMENTS ARE MADE. I AGREE THAT PARENTS, GUARDIANS OR PERSONAL REPRESENTATIVES ARE RESPONSIBLE FOR ALL FEES AND SERVICES RENDERED FOR TREATMENT OF A MINOR/CHILD. I ACCEPT FULL FINANCIAL RESPONSIBILITY FOR ALL CHARGES FOR DENTAL SERVICES OR ITEMS PROVIDED TO THE PATIENT. I UNDERSTAND THAT FILING A CLAIM WITH MY INSURANCE COMPANY DOES NOT RELIEVE ME FROM ANY RESPONSIBILITY FOR THE PAYMENT OF ALL CHARGES.

______________________________ ________________

PARENT / GUARDIAN (print) **DATE**

____

PARENT/GUARDIAN (signature)

Office Policies

Our office policy is that you need to cancel or reschedule your appointment, we need at least a 24 hour notice. If you cancel or reschedule a Hygiene appointment, without a 24 hour notice, you will be charged a $50 fee. If you cancel an appointment with the Doctor there will be a $100 fee.

If you have three missed appointments without a notice, you can be dismissed from the practice with a 30 day notice.

If you are more than 10 minutes late to your appointment, we will have to reschedule the appointment.

Patient Name:_________________________________

Parent Signature:______________________________

Date:____